LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington, Suite 301
Indianapolis, IN 46204
(317) 233-0696
http://www.in.gov/legislative

FISCAL IMPACT STATEMENT

LS 7470 **NOTE PREPARED:** Jan 23, 2005
BILL NUMBER: HB 1596 **BILL AMENDED:**

SUBJECT: Public Assistance Case Management and Copayment Issues.

FIRST AUTHOR: Rep. Brown T **BILL STATUS:** As Introduced
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: This bill eliminates the Primary Care Case Management Program in the Medicaid Program and in the Children's Health Insurance Program (CHIP). The bill requires the Office of Medicaid Policy and Planning (OMPP) to apply to the United States Department of Health and Human Services for a waiver to charge higher copayments to Medicaid recipients for emergency room visits in which only nonemergency services were provided.

Effective Date: Upon passage; July 1, 2005.

Explanation of State Expenditures: *Primary Care Case Management Fees:* This bill would eliminate two Primary Care Case Management (PCCM) programs from the State Medicaid Plan, beginning in FY 2006. In the TANF and CHIP populations, the PCCM fee is $3 per member per month. The PCCM administration fee for the Medicaid Select program for the aged, blind, and disabled population is $4 per member per month. The state and federal expenditures for PCCM fees are included in the Medicaid forecast as shown below.

FY 2005	FY 2006	FY 2007
$9.3 M	$8.5 M	$8.9 M

As OMPP transitions counties to mandatory risk-based managed care which serves the TANF and CHIP populations, the PCCM fees can be expected to be reduced among this population. The Medicaid Select program for the aged, blind, and disabled is OMPP's initial attempt to introduce managed care to the more medically complex and expensive population. The savings attributable to the Medicaid Select program have been estimated to be approximately $14.9 M annually after the initial implementation. The bill would eliminate

the PCCM Medicaid Select fees and probably eliminate the estimated savings in reduced utilization anticipated.

Under the Medicaid program, managed care initiatives operate under a waiver of the federal requirements for recipients to have freedom of choice of providers. As with all waivers, managed care programs must provide proof of cost savings or cost neutrality. The PCCM program in Hoosier Healthwise has been operating for several years and there is no longer Indiana-specific claims data available to compare a fee-for-service patient population to the PCCM managed care population to demonstrate the cost effectiveness of the program. However, studies documented in the professional literature suggest that when managed care savings are achieved, they can range from 5% to 15% relative to fee-for-service. However, the most rigorously designed studies suggest that managed care savings are not assured in Medicaid programs because: (1) states enroll the least costly population - children, (2) Medicaid reimbursement for providers is already very low, and (3) the expenses necessary for outreach and care coordination for a low-income population may be more costly.

Risk-based managed care has been demonstrated to achieve a higher level of savings than the PCCM gatekeeper model, but both models are credited with achieving savings over straight fee-for-service plans. Consequently, a conservative estimate for PCCM managed care savings would trend towards the low end of the range, or 5%. This bill would eliminate the PCCM fees and probably eliminate any savings that may be attributable to the PCCM Hoosier Healthwise program.

Nonemergency Use of Emergency Department Copayments: The bill requires the Office to apply for a waiver to charge higher copayments to all Medicaid recipients for emergency department visits for which only nonemergency services were provided. The bill requires the waiver application contain the following copayment provisions; $20 for the first emergency room visit during which only nonemergency services were provided. The copayment increases to $25 and $50 respectively for subsequent second and third occurrences of nonemergency use of emergency department services in the same calendar month. Any further inappropriate use in a calendar would be subject to a $25 copayment. The fiscal impact of this provision would be dependent upon the approval of the Centers for Medicare and Medicaid Services (CMS). The current Medicaid Program charges a $3 copayment for nonemergency services that are provided in an emergency department. However, federal regulations prohibit requiring a copayment from a pregnant woman, child under the age of 19, an institutionalized individual, or for emergency services. Additionally, if the Medicaid recipient cannot pay, the provider must still provide the service or products subject to copayments. If the patient does not pay the copay, the provider bears the cost as Medicaid reduces the reimbursement to the provider by the amount of the copayment.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 authorized the U.S. Secretary Health and Human Services to waive the nominal copayment provision for up to twice the amount of the nominal amount for nonemergency services provided in an emergency department. This waiver of the nominal amount would allow a copayment of $6. Pregnant women, children, and institutionalized individuals would continue to be exempt. Persons claiming an inability to pay would still have to be provided services while Medicaid reimbursement to the provider is reduced by the amount of the copayment.

Background: Medicaid staff reports that a study of Medicaid emergency department claims data for two counties was done for the first quarter of CY 2004 to determine the prevalence of nonemergency use of emergency departments. Only Hoosier Healthwise and Medicaid Select claims in Wayne and Monroe Counties were searched for encounters that occurred during the hours of 8:00 AM to 5:00 PM, Monday through Friday, with a sole diagnosis of sore throat, ear ache, or cold. A total of 2,037 claims met the study parameters; 892 in Monroe County, and 1,145 in Wayne County. Of the total claims, 50 from each county were randomly

selected for a nursing review to determine if the claim would meet the standards of a reasonable interpretation of an emergency situation. Of the 100 records reviewed, 2 met the emergency standards. All of the claims pulled were for individuals who had a PCCM provider assigned (i.e., they had a physician, yet still went to the emergency department). This small study indicates that PCCM providers are not 100% effective in preventing their patients from inappropriately using emergency departments.

OMPP has started a pilot program in which users who have claims demonstrating multiple nonemergency uses of emergency department services are telephoned and counseled about inappropriate use. PCCM providers are also contacted and advised that enrollees are inappropriately using these services.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program. Medicaid is a jointly funded state and federal program. Funding for direct services is reimbursed at approximately 62% by the federal government, while the state share is about 38%. Funding for administrative services is shared 50/50.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Family and Social Services Administration, Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources: Kristy Bredemeier, Acting Legislative Liaison, Office of Medicaid Policy and Planning, 317-233-2127; and 42 CFR 447.53 ; TEFRA 1982 Sec.131; and "Policy Brief , Henry K. Kaiser Family Foundation at: www.kff.org/medicaid/upload/14747_1.pdf .

Fiscal Analyst: Kathy Norris, 317-234-1360.